A Okay.
Q Do you see the CPT codes --
A Yes.
Q -- in the left-hand column?
A Yes.
Q Okay. And we have a CPT code of 63650 at the top. Do you see that, sir?
A Correct.
Q Okay. That's one of the CPT codes used in this case; is that right?
A Yes. That's for the trial implant.
Q And what does the VA database say that the charge is under their methodology and their database?
A $21,925.21.
Q And is that the 80 percent usual, customary, and reasonable charge?
A Yes.
Q Okay. And what was the amount listed in your report, sir?
A $17,979, which reflects the geographic adjustment factor for Savannah which is .82. So you take the national number, the $21,925.21, multiply that by the geographic adjustment factor for Savannah for outpatient facilities of .82, and that equals $17,979.

Q Okay. Now, is there anything in this VA database that says that the spinal cord stimulator trial and the spinal cord stimulator permanent implantation are added together in one charge?

A No.

Q Okay.

A But it would be, it would be in the DRG -- in an inpatient hospital environment, that would be -- the trial and the permanent would be billed together.

Q And where do you get that information from, sir?

A Just knowing how Medicare works.

Q Can you point to anything that Medicare has published that says that?

A Yeah; with some research I think I probably could.

Q Where would it be found?

A In CMS policies and procedures.

Q All right. Let's look at number six on your findings.

A Okay.

Q You talk about an 80 percent usual, customary, and reasonable reimbursement rate?

A Yes.

Q Is that the VA again?
A Yes. The VA uses the 80th percentile.
Q Okay. So anywhere we look at 80th percentile on your report, you're referring to the VA?
A Correct.
Q Okay. Going on to number seven -- and I think we discussed this earlier, but I want to make sure -- you looked at ambulatory surgery center charges for spinal cord stimulator and you found one entry for DRG 029 at the Medical University of South Carolina?
A Well, it was 14 cases.
Q Okay. And we've already discussed that's the closest hospital you found to Savannah, Georgia?
A Yes; for that DRG.
Q Okay. At number eight you reference the Georgia statewide average for 87 cases. That came from where, sir?
A The CMS database that is --
Q And that is -- I'm sorry. Go ahead.
A I think I listed the specific web source. Let's see. It's footnoted number 13 on page 7. That's the website.
Q What page, sir?

A In my report, page 7, footnote 13 is the link to that database. When you get into that database, you have to select Georgia, and then specifically DRG 029. And that will show you there's 87 discharges. The average charges for those were $82,593.78. It's a little tedious, but it's in there.

Q Okay. Let's take a look at Exhibit 74, please.

A Okay.

Q Was 74 part of the database where you got this information for on finding number eight on the 87 cases from Georgia?

A Well, this describes the database. It's not --

Q Okay.

A This isn't the database itself, but it tells you what's in the database.

Q All right. Let's turn to page 5 of Exhibit 74, please.

A Okay.

Q Down at the bottom at paragraph 6 it discusses "data limitations"; is that correct?

A Yes.

Q Okay. And it says that, "The data in the

inpatient PUF may not be representative of a hospital's entire population served"; is that correct?

A That's correct.

Q "The data in the file" has only -- "only has information for Medicare beneficiaries with Part A fee-for-service coverage, but hospitals typically treat many other patients who do not have that form of coverage," correct?

A That's what it says.

Q And this is the database you used from Medicare; is that right?

A Correct.

Q Okay. And it says, the inpatient PUF does not have any information on patients who are not covered by Medicare, such as those with coverage from other federal programs, like the Federal Employees Health Benefit Program or Tricare, or those with private health insurance, or even those who are uninsured.

A That's --

Q Correct?

A -- correct.

Q And it goes on to say, "Even within Medicare, the inpatient PUF does not include

information for patients who are enrolled in any form of Medicare Advantage plan," correct?

A Correct.

Q And then it says, "The file only contains cost and utilization information, and for the reasons described in the preceding paragraph, the volume of procedures represented may not" fully -- "may not be fully inclusive of all procedures performed by the hospital." Do you see that?

A Yes. I do.

Q And you agree with that statement?

A Yes. And what that means is that, for instance, a procedure that would be performed possibly only on children is not going to be in this database because, you know, basically children aren't covered by Medicare Part A.

Q The fact of the matter is a lot of people in the United States are not covered by Medicare Part A?

A That's true. But it is the largest segment, I think, in the United States. And, you know, the fact remains that hospitals charge Medicare the same way they charge other patients. They don't have different charge masters for different types of payors. They have one charge master. And those

charges are uniformly applied regardless of the financial classification of the patient, so what's billed to a Medicare patient for one service would be billed to any other patient for that same service. What they collect is different depending upon the contractual relationships, but here we're talking about charges. And so the sticker price is the same regardless of the payor.

Q Now, Mr. Blount, you're not a medical doctor?

A You called me doctor when we started back again, but I'm not a doctor.

Q You're not a medical doctor?

A I said I'm not a doctor.

Q Okay. You've never been to medical school?

A I have been in a medical school, but never to attend a class or earn a degree.

Q You haven't taken any medical classes anywhere?

A I've taken CPR.

Q Okay. That's the extent of your medical training?

A That's the only formal class I can think of right now.

Q You don't treat patients for medical

conditions?

A Only close relatives.

Q Now, your opinion in this case, sir, is not that Jackie Orr's future medical care will be free; that you just feel it should be less than what is listed in the reports you reviewed; is that correct?

A I'm saying the charges --

MS. RICHARDSON: Object to the form.

THE WITNESS: -- claimed in the projection are substantially higher than published charge data that I see.

Q (By Mr. Kraeuter) So we can agree that you're not saying Ms. Orr's future medical care should be free. Do we agree on that?

A I guess so.

Q Okay. And your opinion is those charges should be less than what the doctors have listed in their reports?

MS. RICHARDSON: Object to the form.

THE WITNESS: The charges that have been listed in their reports are substantially in excess of published charges.

Q (By Mr. Kraeuter) You don't have any opinions regarding Jack -- the cause of Jackie Orr's injury, do you?

A No.

Q You don't have any opinions on her medical diagnosis?

A No.

Q You don't have any opinions as to whether her condition is permanent or not?

A No.

Q You don't have any opinions as to the appropriateness of the future medical care?

A No.

Q And you're not going to offer any testimony in this case about whether a procedure was necessary or not, or reasonable to perform or not?

A No.

Q And in looking at your report it did not appear that you had any opinion as to the reasonableness of any of the doctors' fees themselves. I'm not talking about medications or ambulatory surgery center fees, but just for payment for the doctor.

A Well, my finding number one deals with the stellate ganglion block procedure professional fee.

Q That's a fair, that's a fair comment.

Other than that, do you have any opinion as to the reasonableness or unreasonableness of any of

the doctor's fees?

A I don't think so.

Q Okay. That would include the fee for implanting the spinal cord stimulator for the doctors fee portion, correct?

A I don't know. I mean, I've not been asked to review those.

Q Okay. And you don't have any opinion as to the reasonableness of the drug testing charges or office visit charges?

A Excuse me just one minute. Let me look back here at one of my documents in the file.

I did look at the charges for the trial implant and the permanent implant.

Q Are you talking about the cost for the ambulatory surgical center, or are you talking about the cost for the doctor to do it?

A The professional fee.

Q Okay. And where does that appear in your report?

A I don't think it's -- I don't think we put that in the report because it really was not remarkable.

Q Excuse me, sir?

A There was -- the charge amount, I believe,

that's projected for the professional fee for 63650 is $2,055, and that's roughly equal to the 50th percentile. And the charge for 63685 to the permanent insertion of the generator was $2,000, and that's a little bit below the 75th percentile. So we really didn't have anything to comment on about those two findings, but I did check them.

Q So, in other words, in other words, you don't have an opinion as to the unreasonableness of those doctors' fees?

A I would say those doctor fees are reasonable.

Q Okay. Now, how much do you earn as an expert witness in terms of consulting, trial testimony, deposition testimony, report preparation for legal cases?

A I'm not compensated separately by that. I have a salary. That includes -- my salary includes my work for Health Law Network as well as for my insurance agency, which is American Benefit Advisors.

Q Do you, do you think that you make as much as $150,000 a year serving as an expert witness in various cases?

A Maybe.

Q Have you made that much in past years

serving as an expert witness?

A Well, as I said, I -- I'm not compensated separately by type of service. I have a single salary that, that is for my work for both Health Law Network as well as American Benefit Advisors. It's not two separate --

Q You own and run --

A -- checks.

Q All right. You own the company, correct?

A I own part of the company.

Q Okay. So you would have access to the data of how much of your business, how much of your fees, how much the company makes comes from you serving as an expert witness, would you not?

A We don't calculate. That's not a calculation that we make.

Q Okay. And your testimony, as you sit here today, is that you are not aware whether you've made as much as $150,000 in past years through your expert witness services?

A Correct. I don't know the number because it's not --

Q Okay.

A I've never calculated it.

Q Does that amount surprise you or shock you

where you say, oh, absolutely I've never made that much in the past as an expert witness in a year?

A I don't feel shocked.

Q Okay.

A So...

Q And how many cases are you serving as an expert witness on at this time where you're preparing reports, preparing for depositions or trials?

A Over 40.

Q Okay. How much time do you spend as an expert witness or serving in your expert capacity as opposed to non-expert in your business?

A I would say expert witness work might be 25 percent of my total professional time.

Q Okay. And have you ever broken down what percentage of your cases you are testifying for the defense versus the plaintiff?

A Yes.

Q And what's that percentage?

A Overall it's been 45 percent for plaintiffs and 55 percent for defendants.

Q Okay. Now, before today, how many times have you met with either Ms. Richardson or anybody from Drew Eckl & Farnham or anybody representing defendant in this case?

A I don't think we've ever met in person.

Q Okay. When were you first contacted in this case?

A Let me see. I believe it was July 26th, 2016.

Q Okay. Do you know what you've charged so far for fees in this case?

A Yes. $7,180.50.

Q Okay. My understanding, sir, is in terms of the materials you were provided by counsel for Macy's that would include the expert report of Dr. Harben, Dr. Niederwanger and Dr. Plumly; is that correct?

A Yes.

Q Okay. Anything else you've been presented or provided by counsel for Macy's?

A The complaint, the answer, the amended complaint, the answer of Macy's to the -- to plaintiffs' amended complaint, the second amended complaint, and defenses and answer of the defendants.

Q Anything else, sir?

A That's, I believe, all that we've been provided by the attorneys.

Q Have you spoken with any of Jackie Orr's doctors in this case?

A Not that I know of.
Q Or corresponded with them in any way?
A No.
Q E-mail? Letter?
A No.
Q Okay. Have you spoken with any other witnesses involved in this case?
A Not that I know of.
Q Now, let's take a look at Exhibit 72 again, sir. That's the Medtronic document.
A Okay.
Q Would you agree with me that this Medtronic document uses a national average to come up with its numbers?
A Well, there's some numbers -- there's CPT numbers. There's, there's all kinds of numbers in here. But for the Medicare national average numbers, those are, as described, Medicare national averages.
Q Did you use this document to come up with any appropriate charges for Ms. Orr?
A No.
Q What did you use this document for?
A To identify how the manufacturer expected the device to be used; you know, what types of patients, what -- and specifically what DRGs they see

this device being used in.

Q And we've discussed those DRGs thoroughly, have we not?

A I'm not sure what you mean by "thoroughly." We probably could discuss it some more if you want to. For instance, I guess a further explanation of the DRGs, 520, even though the reason for the neurostimulator implant is different than RSD, it still does include a neurostimulator implant.

Q And the prices are significantly different, are they not?

A Well, these rates that you're -- if you're looking on page 13 of that exhibit, those are national average payment rates that Medicare has. That's not the charge amounts.

Q Okay.

A But we did identify DRG 520 charges for two Savannah hospitals.

Q Let's take a look at Exhibit 76, please.

A Okay.

Q Now, are these the DRG 029 procedures for the CMS database?

A Yes. So you --

Q Okay.

A I can see from this that you did --

somebody in your office has been to that website that I identified earlier in footnote 13.

Q Okay. So if I look at footnote 13 and I pull up the database I'm getting a whole lot of DRG charges, but the ones that you're looking at under DRG 029 appear on Number Exhibit 76; is that right?

A No. There's also another table at that website that has the statewide averages. You're look -- this is a printout from the national part of the database which would list the individual hospitals; and, again, only disclosing those hospitals who report 11 or more instances. And that number you'll notice in the fourth from the right column, that's the number of cases.

So for the first line item on Exhibit 76 you'll see that for that hospital, NUSC in Charleston, South Carolina, they show 11 instances of that DRG. And that line is actually DRG 28. But that's -- if you want to know the frequency of the cases, that's in that fourth from the right-hand column. So hospitals that have less than 11 instances would not be in this part of the database, but would be included in the statewide average part of the database.

Q And the statewide average part of the

database would list the individual hospitals that reported?

A No. It does not.

Q Okay.

A There's one single line for DRG 29 for Georgia.

Q Okay.

A And that's the one that shows $82,594 rounded.

Q Now, this CMS database does not talk about whether the spinal cord stimulator trial and spinal cord stimulator permanent implant are bundled together or not?

A The database doesn't say that, but that's how Medicare claims are submitted. If you have a planned procedure, a two-step-type procedure such as this where you do the trial and then the permanent if the trial is successful, then the, the hospital submits only one claim. They would hold that claim after the first -- or the trial implant was completed. And then after whatever determination time they choose to make, they decide whether or not a permanent is going to be done or not. If the permanent is done they include the charges for that, and it goes all in on one bill for that DRG 29.

Q Okay. Well, let's look at Exhibit 76.
A Okay.
Q Right at the top, the first entry is University of Alabama Hospital. Do you see that?
A For DRG 29. Yes.
Q In Birmingham?
A Yes.
Q And they charged just over $89,000 to implant a spinal cord stimulator?
A Let's see. Okay.
Q Isn't that correct?
A I don't know. It's kind of hard to read on my copy. It looks like 98,000.
Q 98,000?
A Yes.
Q I'll take it.
Do you know whether the particular procedure and usage of the spinal cord stimulator for Jackie Orr is the same as what's listed in this database? And maybe that's a badly worded question.
In other words, this DRG 029 says it's for spinal procedures W CC, or spinal neurostimulators. Do you see that, sir?
A Yes.
Q So this database and the statewide database

you talked about with 87 other entries could be for procedures that don't include a spinal cord stimulator?

A Possibly.

Q Okay. You can't rule that out?

A I believe that's correct.

Q Okay. And these other possible procedures may have a charge or a cost that's higher or lower than the cost to implant a spinal cord stimulator, correct?

A Yes.

Q But you don't know if they're higher or lower or not, correct?

A Correct. This is not -- they don't disclose individual cases. These are all DRG 29 cases for that --

Q All right.

A -- particular hospital.

Q So if we look at the University of Alabama Hospital entry -- that's the first DRG 029 entry -- it looks like they had 13 of the DRG 029 type procedures in 2014; is that correct?

A Yes.

Q All right. Tell me how many of those 13 procedures were for the implantation of a spinal cord

stimulator.

A You can't tell from this.

Q You don't know?

A Well, yes. I don't know. You can't tell from this.

Q All right. It could be 13, correct?

A Could be as many as 13. Yes.

Q Could be zero?

A It's possible.

Q Okay. Could be 4?

A It could be any number between zero and 13.

Q Okay. And that would be true about the Georgia statewide database you referenced that has the 87 other cases reported; is that correct?

A That's correct.

Q Okay. And looking again at Exhibit 76 at the University of Alabama Hospital entry for the approximately $89,000 -- excuse me, $98,000 charge, that's an average of all 13 of those procedures, correct?

A That's correct.

Q Okay. And so if we have other spinal procedures coded under DRG 029 that are not the implantation of a spinal cord stimulator and those procedures happen to be less than the cost of putting

in a spinal cord stimulator, that's going to skew the $98,000 average number low, wouldn't it?

A Well, it would change the average.

Q It would bring it down?

A Yes.

Q And you don't know how far down under that scenario because you don't have any underlying data?

A That's correct.

Q Okay. Now, let's look at a few of these other charges or entries on Exhibit 76. It looks like the third entry down, St. Joseph's Hospital and Medical Center in Phoenix, Arizona, their average charge is over $148,000, correct?

A Yes.

Q University of California San Francisco Medical Center in San Francisco is over $191,000 for this particular DRG code number, correct?

A Yes. And more than two and a half hours away.

Q University of California Davis Medical Center for the same coded procedure is over $227,000.

A Yes.

Q Correct?

Okay. Now, if we go down to further on down the list to Massachusetts General Hospital,

their average charge is $137,000?

A No.

Q Or over, over $137,000. 134. Over $134,000; is that right?

A Correct. Yes.

Q If we go to San Antonio, Texas down at the bottom, Methodist Stone Oak Hospital, over $132,000, correct?

A Yes.

Q Okay.

A All more than two and a half hours away by drying; some by flying.

Q We can, we can agree, doctor, that these procedures for the, for the implantation of the spinal cord stimulator, it's expensive no matter how you slice it.

A "Expensive" is a relative term. I'm not sure what you want to compare it to.

Q Okay.

A It's not expensive to -- in comparison to, you know, many other procedures. It's more expensive than many procedures too. Generally speaking, though --

Q Now --

MS. RICHARDSON: Hang on. He's answering.

Q (By Mr. Kraeuter) Go ahead.

A Generally speaking, though, the -- it's true that some hospitals are going to have higher charges than average, and others are going to have lower charges than average. That's just how math works. Unless everybody charges identically the same thing, then everybody is average.

So the other important point I would make here is that all of these are inpatient cases. These are patients that stay overnight. Many of these are three or more days of inpatient care even if they don't have a neurostimulator implant. So, you know, the tendency would be any time that you are -- generally when you are comparing inpatient hospital charges to ambulatory surgery center charges, the hospital charges generally are going to be significantly higher because it includes overnight stays and additional services, the cost of standby services, 24-hour departments that run that you just don't have that kind of overhead in an ambulatory surgery center, so...

Q Well, let me ask you this, Mr. Blount, and let's be clear: You're the one that chose what databases to use in this case for your opinions, correct?

A Right. And basically what I'm saying is that the charges for this procedure to be done on an outpatient ambulatory surgery center basis should not exceed what would be charged if it were done on an inpatient hospitalization.

Q Do you have any data on the charges that are charged for the insertation -- or implantation of a spinal cord stimulator by an ambulatory surgical center?

A Yes. That would be included in the VA database because that includes all outpatient facility services, which would be both ambulatory surgery centers and outpatient hospital surgeries.

Q Let's turn back to Exhibit 76, please.

A Okay.

Q Do you know how many days of inpatient care the particular patients received in any of these DRG 029 entries?

A Yes.

Q And where is it listed on Exhibit 79?

A It's not on Exhibit 79.

Q Where would it be listed?

A Well, I pulled -- the AHD database shows for this same line that's in this particular printout -- I think this -- I'm not sure the year is

the same. This is 2015 for University -- South Carolina University Hospital. Their average length of stay for their DRG 29 was 7.4 days, so --

Q I'm sorry. I was not asking -- I wasn't asking the average length of stay. I was asking if you knew the actual days a particular patient for a particular entry of DRG 029 stayed in the hospital.

A Well, I don't know them individually, but the average of all of those at MUSC was 7.4 days. So there would be some more and some less.

Q And some for procedures that may not even include the implantation of a spinal cord stimulator?

A That's possible.

Q It's possible because you just don't know the answer to that?

A No. That DRG includes neurostimulator implants as well as certain other back procedures. But the way that the DRG system works, as I explained in our report, is that it is designed to represent relatively homogeneous utilization of resources within that DRG. So even though it may not include a specific neurostimulator device, all the patients in that DRG should be using roughly the same or similar amount of resources. And so you would expect the charges to be similar.

Q Now, let's go to page 5 of your report, please.

A Okay.

Q Let's look at bullet point number nine. When you search the American Hospital Directory database for the DRG 029 entries, you searched Georgia, South Carolina, and north Florida, correct?

A Correct.

Q And the only entry you found was the one for the hospital in Charleston, South Carolina?

A Correct.

Q And the American Hospital Directory database comes from information from the Centers for Medicare and Medicaid Services; is that right?

A That's correct.

Q Now, going back to Exhibit 76, the second -- the third column from the right which has the dollar amounts -- we'll look at University of Alabama Hospital again at the top. The 89 -- excuse me, the $98,000 charge, is that the total payment amount --

A The 98,000 --

Q -- paid by --

A In the third from right column?

Q Yes, sir.

A That's the charge amount.
Q Okay. Where is the payment amount?
A The payment amount that Medicare makes is in the last column. They paid $17,891 for those patient -- each of those patients. That includes the hospitalization, room and board, lab, drugs, anesthesia, x-rays, the device. All those things are included in the $17,891 payment.
Q Now, all of these directories deal with average prices, correct?
A The AHD directory reports only average prices.
Q And that's -- and that includes VA, Medicaid, Medicare, CMS, American Hospital Directory, PMIC --
A No.
Q -- Physicians' Fee Reference?
"No"?
A No.
Q Which one does not deal with average?
A PMIC, VA, PFR, those do not report averages.
Q Okay. Let's talk about the PMIC. The PMIC book has a discussion in it about super specialist. Are you familiar with that?

A No.
Q You're not familiar with super specialist rates in the PMIC book?
A No.
Q And that if a doctor is part of the select group of super specialists they traditionally charge higher fees for certain procedures?
A I said I'm not familiar with it.
Q Okay.
A Is that like a super --
Q The PMIC -- sir?
A Never mind. Just a joke.
Q The PMIC book has a 75 percent usual, reasonable, customary rate; is that correct?
A Correct.
Q And it's based on 400 million claims that have been built into the database?
A Yes.
Q And that would suggest that at least a hundred million claims are higher than the 75 percent rate?
A No.
Q "No"?
Tell me where my logic is breaking down.
A It's possible that 25 percent of the claims

would be higher, but the 75th percent -- charge point at the 75th percentile could be the same number as the 80th percentile or the 90th or the 100th.

Q You just don't know?

A I don't have the raw data. But the way percentiles work, it's not, it's not a linear relationship between the 75th and 90th or even the 100th percentile. It could be incrementally going up a dollar per percentile or less. It doesn't have to go up at all. It has to at least be the same or greater than the percentile below it.

Q Did you use --

A Mathematically, that's the way it works.

Q Okay. Did you use the PMIC book to deal with spinal cord stimulators in this case?

A No. Only for the professional fee.

Q The ganglion block?

A Well, the professional fee for the insertion of the spinal cord stimulator and the ganglion block.

Q Okay. And do you know how many of the claims listed in the PMIC book for those services actually came from the Savannah, Georgia area?

A No. And I think you've asked that before at least once.

Q Okay. Does this PMIC book instruct providers to never receive 75 -- the 75 percent rate?

A No.

Q Okay. Does the PMIC book take the position that anything over the 75 percent rate is unreasonable?

A No.

Q It's your interpretation that anything over the 75 percent rate is unreasonable; is that correct?

A I didn't say that.

Q Well, is that your position in this case?

A I don't think so. I'm saying -- I'm quantifying how much in excess the projected charges are above the 75th percentile.

Q Okay.

A The judge or the jury may want to make their own reasonableness determinations.

Q Well, aren't you going to testify as to what's reasonable and what's not reasonable in this case? Aren't you going to use those words in trial?

MS. RICHARDSON: Object to the form.

THE WITNESS: Possibly.

Q (By Mr. Kraeuter) Okay. So if you, if you use the words that, that the ganglion block professional charges are more than the 75 percent rate

of the PMIC book and they are reasonable, aren't you making that opinion? Aren't you stating that opinion? Sir?

A Well, I have stated my opinion in the report about the ganglion block. And I said that the, the 75th percentile in the Savannah area is $766, which is 38 percent of what the plaintiffs' projected charge is.

Q How come you didn't you use the 90 percentile rate for the PMIC book?

A Again, I think that's been asked and answered. But, again, the 75th percentile is the more frequently used threshold in the industry.

Q Now, are Medicare rates typically lower than prime insurance rates for medical fees?

MS. RICHARDSON: Object to the form.

THE WITNESS: Well, the charges are generally the same. The payment amount to the provider does vary based upon the contractual relationship.

Q (By Mr. Kraeuter) Now, you mentioned on page 5 of your report that you did online research of peer-reviewed journals?

A Correct.

Q Okay. And did you rely on these

peer-reviewed articles as part of your methodology in this case?

A It's one of the bases of comparison that we made.

Q Okay. Let's take a look at Exhibit 81, please.

A Before we go to that, can we go back to the question you had about the 90th percentile? As you will see when you get the printouts of my files, I did compare the ganglion block $2,000 charge to the 90th percentile. And for the Savannah area the 90th percentile would be $1,023, so the $2,000 projected charge is almost twice what the 90th percentile would be. Even though we didn't say that in the report, I did do the work. It is in the work papers.

Q Okay.

A Okay?

And what exhibit number?

Q 81, please.

A Okay.

Q All right. Was this one of the peer-reviewed articles that you relied on in this case?

A Let me look back at -- I'm sorry.

MS. RICHARDSON: No, no, no. You're fine.

THE WITNESS: We got a very small table here.

Yes. I think it's the one I referred to at the bottom of page 9; number 14, letter B, in my report.

Q (By Mr. Kraeuter) Okay. Is this peer-reviewed article stating an opinion on the reasonableness of the cost of spinal cord stimulation implantations?

A I don't think they -- it's not a study of reasonableness. It's a study that quantified charges and costs.

Q Okay. And this document was written in November of 2006, was it not?

A Yes. I believe so.

Q Okay. And in the first page, that second column down at the bottom it says, "implanted stimulation devices are relatively expensive." Do you see that?

A Yes.

Q Do you agree with that statement?

A Again, I've already answered that. It's relative in comparison to what? It's not --

Q Okay. Well, this is your article.

A It's not expensive relative to, you know,

open-heart surgery, but it is more expensive than a Coca-Cola, you know. It depends on what you want to compare it to.

Q Well, this is an article that you reviewed. You liked what it said and you relied on it in your opinion; is that true?

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't have any like or dislike about the article. I cited the article because it contains an independent determination of what charges and costs are for this type of device over an extended number of patients and over an extended period of time, I believe.

Q (By Mr. Kraeuter) All right. Well, let's go to the next page, the second page of this document.

A Okay.

Q You say that it was an analysis of the cost over a number of patients. If you look at the top, there were only 42 participants in this study, were there not?

A That's correct.

Q Okay. And if you look on the column on the left of that page under where it says "economic analysis," it says the costs were incurred and are reported in 1991 and 1995, United States dollars. Do

you see that?

A Yes, I do.

Q So the costs that were reported are from 21 to 25 years ago, correct?

A Well, it says, "We gathered professional charge data" in the sentence before that, so I would agree to that as far as it relates to professional charge data from John Hopkins.

Q It says, the John Hopkins Hospital billing department provided data on hospitalization-related costs, including admission, room, board, operating room, pharmacy, radiology, laboratory, medical, surgical supplies, physical, occupational, respiratory therapy, and other charges. And then it talks about professional charges.

Do you have any evidence that the numbers used in this particular article are from any other time period other than 1991 to 1995?

A I would have to read back through it again to see.

Q So the short answer, as you sit here today, you do not have any such evidence, correct?

A As I said, I would have to read through the article again to see.

Q Okay. Now --

A But we also point out in my report in number ten on page 9 that the prices for implantable medical devices have a history of declining over time.

Q Now, let's go to the third page of this document, sir.

A Okay.

Q Under "cost effectiveness" it says, the mean cost of randomization to spinal cord stimulators was $31,000 and change. Do you see that, sir?

A Yes.

Q All right. The word "mean" is just another word for "average," is it not?

A It's not the same.

Q It's not the same?

How is it different, sir?

A I'm sorry. Mean is basically the same as the average. Yeah. You're correct.

Q Okay. And so when they talk about the average charge of spinal cord stimulators some 21, 26 years ago, that means that half of the cost to implant these devices was more than what's recorded in this peer-reviewed article, correct?

A Yes. And, conversely, half was less.

Q Okay. And if we go further on down that

column it talks about the cost per patient who achieved long-term success with spinal cord stimulators after crossing from reoperation was over $117,000. Do you see that?

A The cost per patient who achieved -- with reoperation.

Q It says, "after crossing from reoperation."

A That's what it says. I'm not sure what that means --

Q Okay.

A -- "crossing from reoperation."

Q Okay. So you don't know if that means that some people have these spinal cord stimulators need further operations after they get them?

A Well, I do know that some patients do require revision.

Q Okay. Which would be an added cost?

A Yes.

Q Okay. Let's look at Exhibit 82, please.

A Okay.

Q Was this one of the peer-reviewed articles that you relied on in forming your opinions in this case?

A I believe so.

Q Okay. And this was an article that

examined twenty -- let's see, 222 case records at the Cleveland Clinic Foundation between 1990 and 1998?

A Yes.

Q So that's 18 to 26 years ago, correct?

A Yes.

Q And it also talks about the mean patient total reimbursement. Do you see that, sir?

A Yes.

Q Which, as we've said, is just a fancy word for "average"?

A Correct.

Q Now, on that first page in the left-hand column under "results," do you see the words that say, "Patients treated with spinal cord stimulation, slash, peripheral nerve stimulation for pain management achieved reductions in physician office visits, nerve blocks, radiologic imaging, emergency department visits, hospitalizations"? Do you see that?

A Yes.

Q Okay. Do you think that's a good thing?

MS. RICHARDSON: Object to the form.

THE WITNESS: I, I don't have an opinion about good or bad. I mean, it's --

Q (By Mr. Kraeuter) Okay.

A That's part of the report.

Q Do you believe that Jackie Orr should have more physicians' office visits, more nerve blocks, more visits to the ER?

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't have an opinion about that.

Q (By Mr. Kraeuter) Okay. The article goes on and says that the use of spinal cord stimulators results in a large reduction in health care utilization. Do you see that?

A Yes.

Q Do you think that's a good thing?

MS. RICHARDSON: Object to the form.

THE WITNESS: Again, I don't have any opinions about good or bad feelings about any part of this report.

Q (By Mr. Kraeuter) Okay. In the discussion section it says, "The reduced demand for health care resources by patients receiving neurostimulation suggests that peripheral nerve stimulation and spinal cord stimulation treatment, although associated with relatively high initial costs, demonstrates substantial long-term economic benefits." Do you agree with that statement?

MS. RICHARDSON: Object to the form.

THE WITNESS: I agree that the statement is in the report.

Q (By Mr. Kraeuter) You don't, you don't agree whether it's true or not?

A I don't know. I've not -- I did not use -- I did not evaluate the report for determination of truthfulness of any of the statements that are in here. I only relied --

Q Do you --

A -- upon it as an additional source for the general range of what these procedures typically cost.

Q Do you think it's a good idea to try to have substantial long-term economic benefits of reduced costs; reduced medical costs? Do you think that's a good thing?

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't have any objection to that. I don't -- you know, I've not thought about it in terms of developing any professional opinion about it, though. It's not my --

Q (By Mr. Kraeuter) Okay. It goes on and says --

A It's not my area of expertise.

Q Okay. It goes on on the second column of that page to say, "Additionally, these cost data underestimate the true economic impact by failing to account for the effect of chronic pain on disability and other social costs, including effects on morbidity and quality of life, lost earnings, and reductions in productivity." Do you agree with that statement?

MS. RICHARDSON: Object to the form.

THE WITNESS: I agree that the statement is in the report.

Q (By Mr. Kraeuter) Okay. Morbidity, the word "morbidity," can we agree that means death?

MS. RICHARDSON: Object to the form.

THE WITNESS: I'm not sure of the exact definition for morbidity. Mortality would relate to death. Morbidity is something different, I believe; not quite death.

Q (By Mr. Kraeuter) Okay. The document goes on and says, "Management of chronic pain often involves frequent physician office visits and analgesic use, emergency department visits and hospitalizations, numerous radiologic imaging studies, multiple corrective surgeries, and interventional pain management procedures." Were you aware of that?

MS. RICHARDSON: Object to the form.

THE WITNESS: I'm aware that it's in the report.

Q (By Mr. Kraeuter) Okay. It goes on to say, "These treatments are generally administered repetitively and at great expense and fail to provide patients with favorable long-term clinical outcomes." Do you agree with that statement?

MS. RICHARDSON: Object to the form.

THE WITNESS: I'm not a clinician. I didn't participate in this study. I've not been asked to critique this study. And I'm not going to express an opinion about those parts of the study or the report.

Q (By Mr. Kraeuter) Okay. Goes on to say, "Several studies have reported that greater than 50 percent of patients treated with neurostimulation achieve marked improvement in pain relief." Were you aware of that?

MS. RICHARDSON: Object to the form.

THE WITNESS: I see it in the report.

Q (By Mr. Kraeuter) Okay. So you don't have an opinion on that, even though you relied on this document to form your opinion?

MS. RICHARDSON: Object to the form.

THE WITNESS: It's one of the sources of information that's published that deals with the, the cost of this type of service.

Q (By Mr. Kraeuter) Okay. Further it says, "Additionally, in patients with advanced complex regional pain syndrome, neuroaugmentation led to a 50 percent reduction in opioid use and quality of life was reported to improve in the majority of treated patients." Do you see that?

A Yes.

Q You think it would be a good thing for Jackie Orr to have a 50 percent reduction in opioid use?

MS. RICHARDSON: Object to the form of the question.

THE WITNESS: I've got no opinion on those issues.

Q (By Mr. Kraeuter) No opinion on it?

A Those are clinical issues and lifestyle issues. I'm not -- I've not been tendered -- or not been reporting on any professional opinions related to those issues.

Q Do you think it would be a good thing for Jackie Orr's quality of life to improve?

MS. RICHARDSON: Object to --

Q (By Mr. Kraeuter) Is that a good thing, or a bad thing?

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't have an opinion on that.

Q (By Mr. Kraeuter) Okay. Now, if it were your wife that's referenced in this report, would you want her to reduce her opioid use by 50 percent?

MS. RICHARDSON: I'm going to object. This is getting way too argumentative, Scot.

You do not have to answer that question if you don't want to.

MR. KRAEUTER: Ms. Richardson, is there a privilege you're asserting?

MS. RICHARDSON: I'm not asserting a privilege, but this is argumentative. It's outside of his scope of expertise. It's outside of his report. And it's improper. He can do --

MR. KRAEUTER: It's not outside, it's not outs his report.

MS. RICHARDSON: It's far outside of his report, Scot, and you know it. But if he wants to answer it, he can answer it.

MR. KRAEUTER: All right. He has testified, for the record, he has testified that

this is a peer-reviewed article that he relied on forming his opinion. And I am cross-examining him.

MS. RICHARDSON: He relied on a portion of it, Scot. And you know that you're exceeding it. He can answer. I've not instructed him not to answer.

Q (By Mr. Kraeuter) Okay. Answer the question, please, sir.

A This is not part of the report that I relied upon. As explained in my report, number 14 on page 9, these -- there were three studies that we found in peer-reviewed professional journals that disclose the cost of neurostimulation or neuromodulation for treatment of back pain. And those were generally in the 30,000 to $40,000 range, and I included copies of abstracts of those studies and cite them. We're not relying on any other elements of those reports for my opinions; only the costs.

Q So if I'm summarizing this correctly, Mr. Blount, you want to cherrypick the good parts of these peer-reviewed articles that you believe help your opinion and disregard anything else that may not?

MS. RICHARDSON: Object to the form.

Q (By Mr. Kraeuter) Is that fair?

A No. I looked for any studies disclosing costs for these types of devices. These were the only three that I could find. I did not cherrypick any to exclude any reports, and I did not search for reports that had low numbers. I searched for reports that had these devices in studies that included cost or charges.

Q Well, Mr. --

A And I've presented to you all of the information that we did obtain. Nothing has been cherrypicked.

Q Mr. Blount, maybe my question was not clear enough. I'm not suggesting you cherrypicked from different peer-reviewed articles and went with the best of the articles out there. I'm asking whether you cherrypicked the contents within the very peer-reviewed articles you state you rely on for your opinion. You want to take out the parts of the very peer-reviewed articles that you like, but disregard other parts; isn't that true?

MS. RICHARDSON: Object to the form.

THE WITNESS: No. That's not true.

Q (By Mr. Kraeuter) Okay. Let's go to Exhibit

83, please.

A Okay.

Q Is this a peer-reviewed article you relied on in formulating your opinion?

A I believe so.

Q Okay. And this article was written by it looks like three doctors from Canada?

A Yes.

Q Okay. And --

A Well, I'm not sure where they're from. They have Canadian medical affiliations, though.

Q The hospitals that they have privileges at are in -- I can't even say it. Sakas --

A Saskatchewan.

Q Saskatchewan, Canada; is that right?

A Yes. But that doesn't prove where they're from. I mean --

Q Okay.

A -- they could have been born in Afghanistan, for all I know.

Q Well, let me rephrase it.

A Okay.

Q This article was written by three doctors that practice in Canada, correct?

A That's correct.

Q All right. Now, looking at page 107 of the article, first column under "patient selection" it says, we have a large database that includes 350 patients who have undergone SCS, spinal cord stimulation, in the past 20 years. Do you see that?

A Yes.

Q And this paper was written back in 2001?

A Yes.

Q So we're looking at data that automatically is 15 years old, correct?

A Correct. Well, part of it.

Q Okay. And the data could go as far back as about 1980 since it's 20 years of data, correct?

A Yes.

Q So that makes the data up to 36 years old, correct?

A Yes.

Q Now, looking at the bottom on page 107 it says, "To non-Canadian readers, the" low -- excuse me, "the cost calculations presented in this article may seem low, compared with their experience in the United States." And it goes on to say, "The lower financial costs are attributable to differences in pricing by the manufacturer of the implantable devices used and" tightening -- "and tight regulation

by the provincial or federal government of the fee schedules for various professional organizations." That's talking about Canadian fees, right?

A That's correct.

Q And we can agree that in Canada the cost of medical care is much different than in United States?

A It's different.

Q Correct.

A It's different. I'm not sure what you mean by "much."

Q I see.

Let's go to page 108 where it talks about the "costs of implantable devices." It says, the costs for implantable devices were calculated from the 2000 price list provided by the manufacturer, Medtronic of Canada, as charged to Canadian hospitals. Do you see that?

A Yes.

Q Okay. Anywhere in this article that talks about the charges at American hospitals?

A I'm not sure. I was looking for a part of the study that may have disclosed a factor that they used to determine the U.S. equivalent, but that could be in one of the other three studies. I'm sorry, the other two studies. So this could be Canadian only.

Q Okay.

A I don't -- I'd have to go back and review the report in detail. It's a lot of fine print.

Q Now, further on down that column it says, "The pulse generator needed to be replaced after 3.5 to 4.5 years, the average lifespan of its battery." Do you see that?

A Which page again are you on?

Q 108.

A Okay. Just a minute.

Q Just below where it says "costs of implantable devices."

A In that same section of costs?

Q Yeah. It says, "The pulse generator."

A Okay. Oh, I see it. Yes. I see that now. Yes.

Q Okay. Now, I think Dr. Niederwanger said it needed to be replaced every 7 to 10 years?

A Yes; the, the battery life over at least recent years. I don't profess to know about these things going back 20 years ago, but I think there's multiple manufacturers now that say that their battery will need to be replaced every 10 years.

Q Okay. So you --

A Battery life has extended over time as

technology has advanced.

Q Okay. And at the bottom of that column, the very last sentence it says, "The fees paid to the various physicians and surgeons in the study were derived from the year 2000 payment schedule for the Saskatchewan Medical Association." Do you see that?

A Yes.

Q Does that have any bearing on rates in the United States?

A I think they're -- they have some similarity.

Q Let's go to page 114 of the article, please, sir.

A Okay.

Q Down at the bottom of the page in the second column, the right-hand column, it says, "The absolute derived costs may not be directly comparable to those encountered and may be lower than those in the United States or Europe. This difference is a consequence of the nature of the medical delivery system in Canada and differences in pricing by the manufacturer in different countries, which limit absolute costs." Do you see that?

A Not yet. Which paragraph are you in?

Q Very, very bottom of page 114. The last

sentence on the right column is where it starts, and it goes on to page 115.

A Oh, okay.

I think you read that correctly.

Q Okay. So do you agree with that statement?

MS. RICHARDSON: Object to the form.

THE WITNESS: I agree that it's in the report.

Q (By Mr. Kraeuter) Okay. You don't agree that pricing in Canada is much different and, in fact, lower than pricing in the United States and costs in the United States?

A Well, it says it "may be lower." It doesn't say --

Q Mm-hmm.

A The word "much" is not, I don't think, in this paragraph.

Q Okay.

A It says it "may be lower."

Q Have you undertaken in this case to do any study to determine the relative difference in pricing and costs for medical care in Canada and the United States?

A No.

Q Let's take a look at Exhibit 84.

A Okay.

Q Did you rely on this peer-reviewed article?

A No, but it looks somewhat familiar. I recognize the author's name Kumar, but it's not cited in my report. But, see, this -- I think I have read this. And it does contain both U.S. dollar and Canadian dollar amounts.

Q Well, let's take a look at page 8 of your report, please, sir. Down at the bottom you talk about independent research on spinal cord stimulation costs. Do you see that, sir?

A Yes. Oh. Yes. This is that article. This is referring to that article.

Q Okay. So you did rely on this in forming your opinions in this case?

A Yes.

Q Okay. And this is also, again, written by Dr. Kumar, the Canadian doctor?

A Yes.

Q Okay.

A So I do have this.

Q And this article was written in 2009?

A Correct.

Q And I believe if you look on the method section of the first page it analyzed 197 cases

between 1995 and 2006?

A Yes.

Q Okay.

A I believe this is the most recent study that we could find.

Q Okay. And in there it has a cost for Blue Cross/Blue Shield, which is private insurance?

A Yes.

Q And the Blue Cross/Blue Shield cost back in 2009 was $57,896 to implant a spinal cord stimulator?

A That's what they report.

Q Okay. And Medicare costs were $32,882; is that right?

A Yes. That's what it says.

Q So there's a difference between Blue Cross/Blue Shield costs and Medicare costs, correct?

A Yes. And I believe they're referring to the amount of the reimbursement; the payment.

Q Does -- is there anywhere in this article that talks about what's charged?

A I'm not sure. I'd, again, have to go back and read all the words. A lot of times I've seen in studies -- other studies, not necessarily this one -- but the researchers sometimes confuse the term "charge" and "cost," as you have in some of your

questions. But --

Q The same question -- I would have the same question for exhibits 81, 82, and 83. Do any of those reports deal with what's paid versus what's charged for the spinal cord stimulator?

A Yes. I believe the 2007 study collected charge data for the 42 patients.

Q And it looks like the, the cost for annual maintenance under Blue Cross/Blue Shield is $7,277?

A Yes.

Q Back in 2009?

A I believe so.

Q Or, I guess, somewhere between 1995 and 2006, to be accurate?

A Well, the $7,277, the amount that's quoted in the result, is part of the report.

Q Right.

And that's for data between 1995 and 2006?

A Yes.

Q Now, it looks like if we go to page 566 of the study --

A Okay.

Q -- in that first column where it says, "Cost comparison with the United States" --

A Yes.

Q Okay. It says, "We have chosen the payment schedule from the state of Texas." Do you see that, sir?

A Yes.

Q Is Jackie Orr from Texas?

A I'm not sure where she's from.

Q Okay. Do you know what it means when they say, "We've chosen the payment schedule from the state of Texas"?

A Not exactly.

Q Do you know if that's a reference to a Workers' Compensation fee schedule for physicians and hospitals?

A It doesn't say that.

Q Okay. Do you know if it's Medicare charges or payments from the state of Texas?

A Well, it says they're using two major insuring agencies in the United States, Medicare and Blue Cross/Blue Shield. So if they said that in the proceeding sentence, I would assume that's the, the sources that they're referring to in the next sentence. Why would I assume --

Q Do you --

A -- that it would be Workers' Comp?

Q Do you know that for a fact?

A Well, it certainly makes more sense than guessing that it would be Workers' Compensation.

Q Sir, my question was: Do you know that for a fact?

A The sentence before that says that they, "To provide a clear understanding of the financial impact for implanters in the U.S., we are providing a parallel analysis of our frequency data, using the payment schedule of two major insuring agencies in the United States, comma, namely, Medicare and BCBS, period. We have chosen the payment schedule from the State of Texas, as it most closely approximates the mean payments for the country." I think it's a logical inference that the second sentence reference to payment schedule is the same payment schedule referred to in the immediately preceding sentence.

Q All right. Do you know if this Texas payment schedule that's referred to in the document is the same as Savannah, Georgia medical charges for the same services?

A I do not know.

Q Let's take a look at page 567, please.

A Okay.

Q Okay. The table -- excuse me. Let me see here.

I'm sorry. Let's go to page 568.

A Okay.

Q Table 4, there's a reference to a rechargeable device. Do you see that; rechargeable system?

A I don't see it yet. In the table on page --

Q Table 4.

A Oh. Table 4. Okay.

Q Table 4 at the bottom of the page.

A Okay. Yes. I see that.

Q Okay. And it says, "US MC." Do you know what that stands for?

A No. I'm not certain.

Q Okay. It's listing U.S. dollars; USD, correct?

A Yes.

Q And it has a rechargeable system of over $43,000.

A Yes.

Q Okay. Do you know what that rechargeable system is they're referring to?

A Not without reading the report again.

Q Let's go to Exhibit 85, please. Do you have that in front of you?

A Yes.

Q Is this a document that you relied on in formulating your opinion, or opinions in this case?

A Yes. We cite that in number ten on page 9 of my report.

Q Where did this document come from?

A Page 15. Well, I have the web link footnoted number 15 on number -- page number 9.

Q Okay.

A Apparently somebody in your office found it because they printed it out.

Q And this document examined empirical evidence on reported average price trends for several major categories of implantable medical devices over the period 2007 through 2011; is that correct?

A That's correct.

Q Okay. And it does not address the price trend after 2011, correct?

A Correct.

Q Do you know what the price trend has been for implantable medical devices since 2011 to today?

A No. I have searched for --

Q Okay.

A -- studies that would disclose that; have not found one yet.

Q Now, let's talk about the study, scope, and approach. Okay? They looked at the average pricing data for selected device categories. Do you see that?

A Yes.

Q And they looked in the following seven categories of medical devices: Cardiac resynchronization therapy defibrillators, implantable cardioverter defibrillators, pacemakers, artificial hips, artificial knees, drug eluting stents, and bare metal stents. Do you see that, sir?

A Yes.

Q Is a spinal cord stimulator referenced anywhere in the category of devices that were part of this particular study?

A No.

Q Now, Mr. Blount, can we agree that many private insurance carriers say that a doctor or an ambulatory surgical center can bill above the 75 percentile usual, reasonable, and customary charge amount and still be reasonable?

A It's possible.

Q In fact, the Veterans Administration say you can go as high as 80 percent, correct?

A That's not what they say.

Q I see.

Now, if a doctor bills above the 75 percent rate or the 80 percent rate, does that mean the doctor's committing fraud?

A No.

Q Does that mean the doctor's violated some law?

A Not that I know of in Georgia; maybe some other states.

Q Okay. Are any of the charges in either Dr. Niederwanger or Harben's reports under the uniform customary and reasonable rates -- the usual, customary, and reasonable rates?

A Possibly.

Q Okay. Did you look at all of the, all of the future medical charges that Dr. Niederwanger and Dr. Harben have recommended in this case?

A I have the list --

Q Okay. And --

A -- from at least Dr. Plumly.

Q Okay. And in looking at that list, do any of those charges come underneath or below the usual, customary, reasonable charge rate?

A It's, it's almost impossible to tell because he did not provide the specificity of CPT

codes for a lot of these things. So it's -- you know, I had a limited ability to evaluate some of his data, or charges. Those that I did evaluate I have provided the information for in the report, or in the material that is included in my other research file that I've provided to you now.

Q Now, is there any law in the State of Georgia that says what is reasonable and not -- what is not reasonable in regard to medical bills?

A I don't know.

Q Okay.

A You'd have to consult --

Q Is there any rule -- go ahead.

A You'd have to consult with an attorney on that, probably.

Q All right. Is there any rule or law that you know that dictates what a doctor's office or an ambulatory surgical center can charge a patient that doesn't have insurance or Medicaid or Medicare or VA benefits?

A I think there's a law that says you can only charge for what you do.

Q Okay. But in terms of setting the rate for what you do is there any such law or rule?

A Maybe in the Worker Comp area of the law.

Q Okay. How about for someone that doesn't have Comp, VA benefits, Medicaid benefits or private insurance or Medicare? Any law or rule that says what a doctor has to charge, or may charge?

A Not that I know of, but I don't profess to have the ability to opine on what the law says.

Q Do you know what the cost of medical care would be if someone walked in off the street to Dr. Harben, Dr. Niederwanger, or the ambulatory surgical center that Optim has for the same type of procedures that we've been talking about in this case?

A No. I don't have their fee schedule.

Q Do you agree that Jackie Orr is entitled to have a doctor of her choice?

A I guess.

Q Okay.

A I've not been asked to opine on that, but I don't know any reason why she shouldn't.

Q In the Savannah, Georgia area, can we agree that different doctors charge different amounts for their services?

A Some do. Some charge the same as other doctors. It does vary.

Q And as a general rule, there's nothing

wrong with doctors charging different amounts for the same service?

MS. RICHARDSON: Object to the form.

THE WITNESS: I'm not sure what "wrong" means; if you mean illegal. I don't, I don't know of a law that would prohibit them from charging a different amount.

Q (By Mr. Kraeuter) Well, do you think it's improper for different doctors to charge different amounts for the same services?

MS. RICHARDSON: Object to the form.

THE WITNESS: Not necessarily. You know, if one doctor is charging, you know, ten times what the other doctors charge that would seem to be at least questionable and certainly out of the market range. I mean, if I was spending my money I would not want to spend ten times what everybody else is charging.

Q (By Mr. Kraeuter) Can we agree that sometimes better doctors charge more than other doctors that aren't quite as good?

MS. RICHARDSON: Object to the form.

THE WITNESS: I'm not sure how you would measure good and not quite as good, though.

Q (By Mr. Kraeuter) Well, can we agree that a

board-certified physician may charge more than one -- than a doctor that's not board certified?

MS. RICHARDSON: Object to the form.

THE WITNESS: They could; or they could charge less.

Q (By Mr. Kraeuter) Okay. Now, you do agree that the doctors should be paid for their medical care and treatment that they're rendering?

A Yes.

MS. RICHARDSON: Did we lose sound?

Q (By Mr. Kraeuter) Now, are you aware of whether somebody like Jackie Orr can go to their physician and tell the physician what she will or will not pay for medical services?

A Yes. She can do that.

Q Do you know the likelihood of success she would have in doing that?

MS. RICHARDSON: Object to the form.

THE WITNESS: No.

Q (By Mr. Kraeuter) Okay.

A I don't know the chance of success.

Q Have you ever gone to one of your physicians and said, "Look, I'm not going to pay a hundred dollars for this procedure, but I'll pay you 75"?

A Not those numbers. No.
Q Have you ever negotiated with your physician?
A Yes.
Q Or any medical care provider?
A Yes.
Q How many times has that happened?
A I don't recall, but it is becoming much more common now with very high deductibles on insurance plans. And many people who have health savings accounts will do that, I know from experience. And there are a number of services that have cropped up on the internet that offer the ability for individuals to outsource that negotiation process.
MR. KRAEUTER: And I'll object to that as -- to that response as speculative.
MS. RICHARDSON: That's not what he wanted to hear.
Q (By Mr. Kraeuter) Would you expect someone like Jackie Orr to know what a CPT code is?
A I don't know. I don't know her background. She could be a nurse for all I know.
Q Would you expect her --
A She could be --

Q Go ahead.

A She could be a nurse or a coder or maybe has looked at her explanation of benefits if she's had insurance. A lot of times CPT codes are included on EOBs, and many times they include a brief explanation of what that CPT code definition is.

Q Would you expect Jackie Orr to know what "usual, customary, and reasonable" means regarding medical expenses?

A I have no idea.

Q Okay. Would you expect her to know what the range of reasonable medical charges are?

A Not necessarily, but, I mean, she could call and ask.

Q Okay. You're not saying in this case that Jackie Orr had any involvement in setting the amount of the future medical charges in this case, are you?

A That's certainly not in my report.

Q What's that?

A It's certainly not stated in my report.

Q Okay.

A I've not even thought about that until you mentioned it.

Q Now, we talked earlier about someone like Jackie Orr as a patient going to the doctor and

asking the doctor to reduce their medical bill. Is the doctor legally required to do that?

A No.

Q Is there anything that would compel the doctor to do that or force the doctor to do that?

A Maybe compassion.

Q Okay. And if the doctor doesn't reduce their charges and the patient doesn't pay the portion that they're responsible for, they can be sent to collections, can't they?

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't know. Possibly.

Q (By Mr. Kraeuter) Okay. Now, in this case if the jury does not award Jackie Orr some of her medical bills as damages in the case and her physicians don't reduce what they've charged her for the medical care, she's the one that's going to have to make up the difference, isn't she? She's the one that's going to have to pay, is she not?

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't know. I don't know what her arrangement is with the physician or the ambulatory surgery center.

Q (By Mr. Kraeuter) Now, one of the ways to look at the reasonableness of medical bills is to look

at the cost for the medical provider to provide the services; is that correct?

A That methodology I think is rarely done.

Q But it's -- it is a methodology? It is an approach, is it not?

A Yes.

Q And, in fact, it's one that the medical -- that the American Medical Association says is an accepted approach to setting rates, fees and charges, correct?

A I have heard other people say that. I've never seen the actual publication from AMA saying that.

Q Okay. All right. So if a physician or ambulatory surgical center has a certain type of specialized equipment that costs more than perhaps another surgery center down the road or a hospital doesn't have such advanced equipment, but that equipment costs more, the specialized equipment costs more, it would be appropriate for the doctor or the surgery center to charge more because their overhead is higher because they have better equipment, correct?

MS. RICHARDSON: Object to the form.

THE WITNESS: Some of your assertion there